



## King's Research Portal

### *Document Version*

Publisher's PDF, also known as Version of record

[Link to publication record in King's Research Portal](#)

### *Citation for published version (APA):*

Sandall, J., Coxon, K., Mackintosh, N. J., Rayment-Jones, H., Locock, L., & Page, L. (2016). Relationships: the pathway to safe, high-quality maternity care: Sheila Kitzinger symposium at Green Templeton College, Oxford: Summary report. Green Templeton College, Oxford.

### **Citing this paper**

Please note that where the full-text provided on King's Research Portal is the Author Accepted Manuscript or Post-Print version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version for pagination, volume/issue, and date of publication details. And where the final published version is provided on the Research Portal, if citing you are again advised to check the publisher's website for any subsequent corrections.

### **General rights**

Copyright and moral rights for the publications made accessible in the Research Portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognize and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the Research Portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the Research Portal

### **Take down policy**

If you believe that this document breaches copyright please contact [librarypure@kcl.ac.uk](mailto:librarypure@kcl.ac.uk) providing details, and we will remove access to the work immediately and investigate your claim.

# Relationships: the pathway to safe, high-quality maternity care

Sheila Kitzinger symposium  
at Green Templeton College, Oxford:  
Summary report



GREEN TEMPLETON COLLEGE | OXFORD



The Sheila Kitzinger Programme at Green Templeton College, Oxford, is funded by Sheila's husband Uwe Kitzinger, Emeritus Fellow of Green Templeton College, former Director of the Oxford Centre for Management Studies (1980-84) and the first President of Templeton College (1984-1991)

# Acknowledgements

**Writing and editorial group** on behalf of the Sheila Kitzinger symposium group  
Professor Jane Sandall<sup>1</sup>, Dr Kirstie Coxon<sup>2</sup>, Dr Nicola Mackintosh<sup>3</sup>,  
Hannah Rayment-Jones<sup>4</sup>, Professor Louise Locock<sup>5</sup>, Professor Lesley Page<sup>6</sup>

<sup>1</sup> Professor of Social Science and Women's Health, Division of Women's Health, Faculty of Life Sciences & Medicine and Florence Nightingale Faculty of Nursing and Midwifery, King's College London; and lead for maternity and capacity building themes at NIHR CLAHRC South London.

<sup>2</sup> Senior Lecturer, Department of Midwifery, Florence Nightingale Faculty of Nursing and Midwifery, King's College London.

<sup>3</sup> Postdoctoral Fellow in Improvement Science, King's Improvement Science, Health Service & Population Research Department; and Research Fellow, Division of Women's Health, Faculty of Life Sciences and Medicine, King's College London.

<sup>4</sup> Midwifery Tutor, Florence Nightingale Faculty of Nursing and Midwifery, King's College London

<sup>5</sup> Associate Professor and Director of Applied Research, Health Experiences Research Group, Nuffield Department of Primary Care Health Sciences; Health Experiences Fellow, Oxford NIHR Biomedical Research Centre; and Research Fellow, Green Templeton College, Oxford.

<sup>6</sup> President of the Royal College of Midwives; Visiting Professor Florence Nightingale Faculty of Nursing and Midwifery, King's College London; and Adjunct Professor to University of Technology Sydney and Griffith University, Australia.

**Critical reader**, Professor Eugene Declercq, Boston University

## Sheila Kitzinger symposium group

The symposium included the following individuals all of whom attended

in a personal capacity rather than representing their employing organisations:

Professor Ruth Boaden, Professor John Bowers, Professor Peter Brocklehurst, Sheena Byrom, Professor Helen Cheyne, Dr Kirstie Coxon, Baroness Julia Cumberlege, Professor Eugene Declercq, Heidi Eldridge, Milli Hill, Dr Jennifer Hollowell, Dr Uwe Kitzinger, Professor Louise Locock, Professor Ingrid Lunt, Dr Nicola Mackintosh, Miss Margaret Matthews, Carmel McCalmont, Dr Sarah McMullen, Professor Lesley Page CBE, Professor Donald Peebles, Dr Rick Porter, Elizabeth Prochaska, Hannah Rayment-Jones, Dr Mary Ross Davie, Professor Jane Sandall, Rebecca Schiller and Martin Wilkinson.

Sheila Kitzinger Programme  
Supported by  
Green Templeton College  
Oxford  
[www.gtc.ox.ac.uk](http://www.gtc.ox.ac.uk)  
(01865) 274770



**The study group** was curated by Professor Lesley Page, President of the Royal College of Midwives.

Jane Sandall, Kirstie Coxon and Nicola Mackintosh are supported by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care South London at King's College Hospital NHS Foundation Trust. The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.

**The infographics** were created by Nisha Mattu (Innovation and Improvement Assistant), supported by Alaur Rahman (Data Analyst) and Melanie Ward (Head of Information) in the Technology & Information team at the Health Innovation Network, the Academic Health Science Network (AHSN) for south London. One of 15 AHSNs across England, the Health Innovation Network connects academics, NHS commissioners and providers, local authorities, patients and patient groups, and industry in order to accelerate the spread and adoption of innovations and best practice, using evidence-based research across large populations. Working as catalysts of change across health and social care economies, the AHSN enables health improvements and economic growth.

**Citation:** Please cite this report as:

Sandall, J., Coxon, K., Mackintosh, N., Rayment-Jones, H., Locock, L. and Page, L. (writing on behalf of the Sheila Kitzinger symposium) (2016) Relationships: the pathway to safe, high-quality maternity care Report from the Sheila Kitzinger symposium at Green Templeton College October 2015. Green Templeton College, Oxford.

# Contents

Introduction	5
Executive summary	7
The nature of the problem	9
Different models of maternity care	10
Continuity of care: improving outcomes and experience through relationship-based care	15
Continuity models of maternity care: descriptions and features	18
Scale up and implementation	21
Evidence gaps and recommendations for future research	27
Conclusion	28
Examples of continuity of care services	29
References	35

# Introduction

The Sheila Kitzinger study group met at Green Templeton College, Oxford, in October 2015. The group included health service leaders, academics, and representatives from a range of lay groups who aimed to take forward the legacy of Sheila Kitzinger's work on relational continuity in maternity care.

**'A woman's relationship with her maternity providers is vitally important. Not only are these encounters the vehicle for essential lifesaving health services, but women's experiences with caregivers can empower and comfort or inflict lasting damage and emotional trauma.'**

*White Ribbon Alliance, Respectful Maternity Care, 2011*

Pregnancy and childbirth are an intensely important time for women. What happens during pregnancy, birth and beyond, and the way a woman is treated during childbirth can have profound consequences. It is clear that a major activity of healthcare workers is coping with complexity, due to the multiple medical, obstetric, social, emotional and family issues that pregnant women may experience at the same time. In particular, health-care workers need to anticipate and cope with the gaps between different services that come about as a consequence of care complexity. Safe and high-quality care that leads to healthy physical and psychological outcomes, as well as supporting strong family relationships and reducing the impact of inequalities, requires models of care that meet each woman and baby's health, personal and social needs and preferences. Safety is increased by understanding and reinforcing the ability of practitioners to bridge gaps or discontinuities in care. This more personal and appropriate care should reduce variations in outcomes between services, while providing care that is tailored to each individual woman's needs, values and preferences. The importance of relationships in health care is a global concern, and continuity of midwife care is at the heart of maternity policy in New Zealand, Australia and Canada.

The study group aimed to help promote understanding of how we might, within the NHS, implement the evidence, scale up and sustain relational continuity in maternity care, and highlight where there are gaps in the evidence about the operation and application of relational models of care. Despite strong evidence of benefit to women and their families, not all women in the UK have access to services where they get to know their midwife. The study group aimed to develop recommendations on ways of expanding access to these services for which there is strong evidence of benefit. This report focuses on relational continuity of care, because there is compelling evidence that ongoing supportive relationships between women and their maternity care provider improves health outcomes for women and babies, and women's experiences of care.

## Continuity of care – policy context in the UK

A recurrent theme in the policy and provision of maternity services (Changing Childbirth (1993), NSF Standard (2004), Maternity Matters (2007)) has been midwifery continuity of care across the United Kingdom. Each country within the UK has policy drivers in place to implement continuity of care with a named midwife and quality standards. These are:

- England: NICE quality statement for patient experience (NICE 2012), NHS England Mandate (NHS 2015)
- Scotland: A Refreshed Framework for Maternity Care in Scotland (2012), Getting It Right For Every Child (GIRFEC 2012)
- Wales: A Strategic Vision for Maternity Services in Wales (2011)
- Northern Ireland: A Strategy for Maternity Care in Northern Ireland 2012-18 (2012).

The recent National Maternity Review in England (2016) has highlighted the importance of continuity from a service-level perspective and further information is awaited from the ongoing maternity review in Scotland. In line with national commitments, the role of the midwife in strengthening public health, and the compelling evidence-base for continuity of care makes it imperative that commissioners and planners start to build continuity of care models into maternity service requirements (RCM 2016).

The National Maternity Review in England (2016) highlights seven key priorities to drive improvement and ensure women and babies receive excellent care wherever they live. These include personalised care, and continuity of care. This report addresses the implementation and scale up of continuity of care.

In addition, the NHS England Five Year Forward View (2014) encourages innovative models of care, different approaches to funding for population outcomes and work across systems to develop sustainability and transformation plans (as announced via NHS England planning guidance). This creates opportunities to really address continuity at a population and system-level with the right cross-sector leadership support.

# Executive summary

## Health outcomes

Women at low and higher risk who received continuity of care from a midwife they know during the antenatal and intrapartum period (compared to women receiving medical-led or shared care) are 24% less likely to experience preterm birth, 19% less likely to lose their baby before 24 weeks gestation, and 16% less likely to lose their baby at any gestation. Women were also more likely to have a vaginal birth, and fewer interventions during birth (instrumental birth, amniotomy, epidural and episiotomy). These results are from a Cochrane review of continuity of midwife care provided by team and caseload midwifery of women based on 15 trials involving 17,674 women (Sandall *et al* 2015).

## Women's experience

Women who received continuity of midwifery care found services easier to access and were seven times more likely to know the midwife who looked after them at birth. They reported greater satisfaction with information, advice, explanation, venue of delivery, preparation for labour and birth, choice for pain relief, were more positive about their overall birth experience, with increased agency and sense of control and less anxiety (Mclachlan *et al* 2015).

## Cost

Current evidence suggests a cost-neutral effect because of shorter hospital stays for mother and baby, fewer tests and interventions (Kenny *et al* 2015), and continuity models of care are more flexible and match input of midwives' time to women's needs, especially in labour and birth (Devane *et al* 2010). Cost saving depends on caseload size and coverage. Long-term cost savings on reduction of preterm birth have never been estimated. More research is needed to understand the costs and savings associated with continuity models of maternity care.

## Models of care

Only relational models of health care have been shown to impact on clinical outcomes, meaning a supportive relationship over time between an individual and their care provider ensures good-quality care, and effective partnership, coordination and advocacy (Freeman *et al* 2007). All models in the Cochrane review provide continuity of midwife care between pregnancy and the intrapartum period.

There are many models providing relational continuity. Effective continuity midwifery models can be community- or hospital-based, and provide care to all women in a geographical area or only to women who require additional specialist input, where continuity of midwifery care is provided within a multidisciplinary team. Care can be provided to women who are healthy, or to those who have medical or obstetric complications.

Every woman needs a midwife and some women will need additional care from a range of specialists. In all these models, care can be provided by a small team or caseload model in a group practice, with as much care as possible being provided by the named midwife throughout pregnancy, birth and the postnatal period.

## Mechanism

Advocacy, trust, choice, control and listening to women are important processes linking relational continuity of midwifery care models with improved outcomes and experience. In community-based models, midwives are oriented towards the woman and her community, rather than towards the needs of the institution and pre-emptively provide care where and when it is needed. They harness additional support from psychiatric services, domestic violence advocacy and other support (including translation services, early health visitor input, children's centres, housing and parenting support). Women and midwives report that women are more likely to disclose potentially harmful behaviours (such as smoking or drinking) and be



prepared to trust advice and accept ongoing referral (Finlay and Sandall 2009). Hospital-based teams which look after high-risk women increase trust and collaboration between midwives and other professionals.

### Scale up and implementation

Commonly recurring, desirable features of successful implementation include: effective planning, project management, communication, collaboration, and teamwork; useful tools should be in place, with a clear implementation strategy, staff and organisational ownership, and effective change leaders / champions; the proposed implementation must meet the identified need and be consistent with the organisation and stakeholders' aims; monitoring, evaluation and feedback should be built in, with incentives, flexibility, and autonomy for those working in the model. There also needs to be standardisation, while the implementation should be tailored to the local context. This requires the necessary human and financial resources including time (Braithwaite *et al* 2014).

Scale up needs to be sustainable and acceptable to providers. Burnout is caused by a lack of job control and an absence of sense of achievement at work. Continuity midwifery models are associated with lower levels of midwife burnout and higher professional satisfaction (Sandall 1998), because they provide high levels of personal control over how work is organised, and result in meaningful relationships with women (Mollart *et al* 2013). However, control of caseload size, working hours and self-management are key organisational principles. Most sustainable models contain around six whole time equivalent (WTE) midwives in self-managing practices, with caseload sizes varying from 28-40 births / WTE per midwife, depending on the case mix.

### Conclusion

Relational continuity maternity models should be scaled up because there is compelling evidence that ongoing supportive relationships between women and their maternity care provider improves outcomes and experiences of care. Outcomes improve for women at both low and high risk of medical and obstetric complications, and benefits of continuity are also experienced by women with complex social problems, socio-economic deprivation and those from black and minority ethnic backgrounds. These are the very groups who are at higher risk of maternal and infant death and morbidity as a result of pregnancy and birth, and who more often experience failures in care.

Relational continuity maternity models improve job satisfaction and a sense of autonomy for midwives that practice in these models, and improve trust and effective collaboration between care providers. Success will depend on fidelity to key principles such as high relational continuity with a named midwife, control of caseload, appropriate team size and self-management. Continuity models can be achieved without extra financial resource, although additional investment will be required to support initial implementation and scale-up activity.

# The nature of the problem

Birth in the UK is generally very safe for the majority of women and their babies (King's Fund 2008), but problems in maternity care persist, and we know that these problems disproportionately affect women and babies from some ethnic groups and those who are socio-economically disadvantaged.

## Outcomes for women and babies

- There are wide variations across trusts in stillbirth and neonatal death rates, even after adjustment for deprivation (MBRRACE 2015)
- Babies of Black or Black British and Asian or Asian British ethnicity had the highest risk of extended perinatal mortality with rates of 9.8 and 8.8 per 1,000 total births respectively (MBRRACE 2015a)
- Women living in socio-economic deprivation with complex social factors have the highest maternal and infant mortality rates in the UK with significantly more infants with low birth weight or preterm birth (MBRRACE 2014)
- Many of the women who died within a year of pregnancy had long-standing and multiple morbidities occurring prior to, during and after pregnancy, and they often led socially complex lives (MBRRACE 2015b)
- Pregnancies in women living in areas with the highest levels of social deprivation in the UK are over 50% more likely to end in stillbirth or neonatal death (MBRRACE 2015a)
- There remain large variations in provision of information and options for place of birth, and childbirth interventions (National Audit Office 2013).

## Women's experiences of maternity care

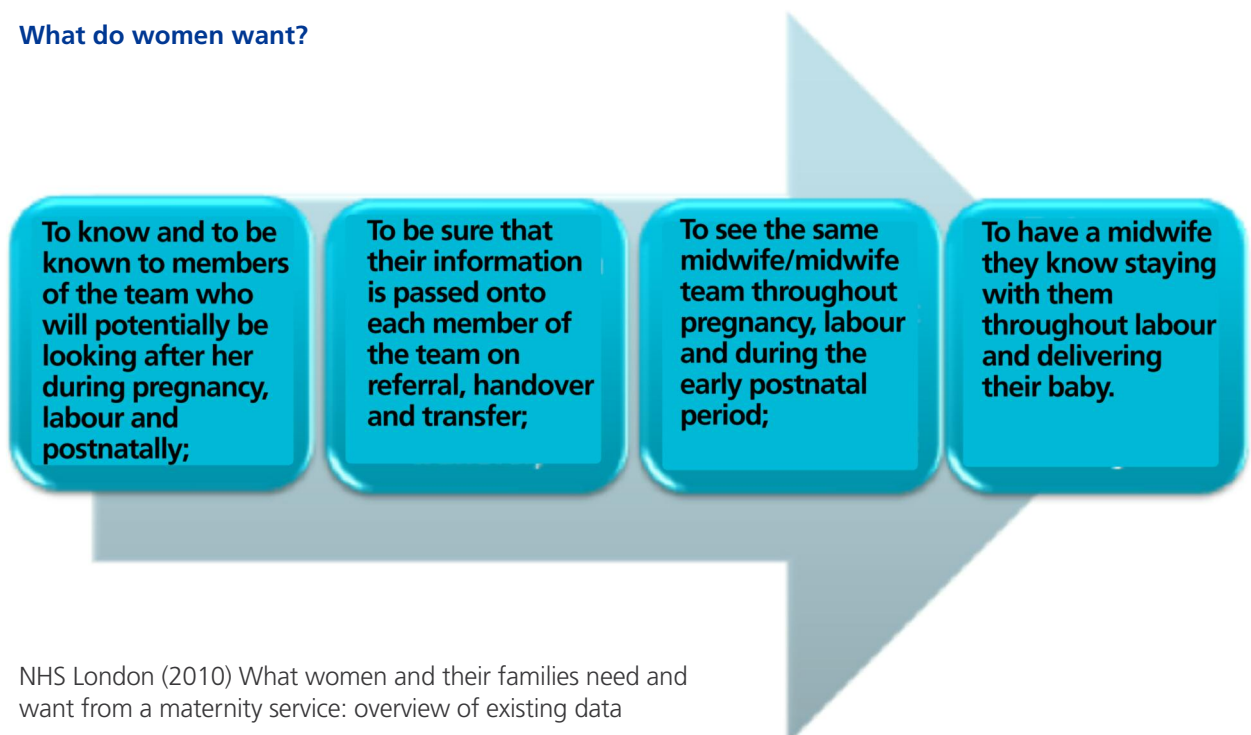
- There is evidence that women are not listened to when they express concerns about their own or their baby's health, and that important information is not always shared with women (SANDS 2009)
- The report on the Morecambe Bay maternity care investigation (Kirkup 2015) found failures in care that contributed to maternal and baby deaths, and identified poor inter-professional working relationships and failures in care planning as key elements of these incidents. Care and compassion were seen as less important, yet integral to system failures
- The Care Quality Commission (2015) and the Having a baby in Scotland 2015 maternity service user review (Scottish Government Care Experience Programme 2015) both identified that around one in five women felt that they were left alone during labour at a time that worried them and did not have complete confidence in those caring for them
- Care fragmentation and a lack of personalised focus within maternity care are key contributors to problems of safety and quality care (SANDS 2015). These factors have a negative impact on women's experience of maternity care
- The Annual Report from the Chief Medical Officer, The Health of the 51%: Women, recognises the effect of social inequities and outlines the contribution of a human-rights approach to women's health (Leigh *et al* 2015). Women have reported dehumanised care, and a lack of personalised focus within maternity care. Women's basic rights to dignity and consent in birth sometimes remain unmet (Birthrights 2013). In response to this, Birthrights has called for a rights-based approach, where women are listened to, respected and regarded as autonomous and capable of making decisions (Birthrights 2015a).

# Different models of maternity care

The maternity system is complex and has problems of coordination, communication, and cooperation. The fewer boundaries health information has to travel across, the less potential there is for error (Vaughan 1999). Women have a right to safe and high-quality maternity care, and the midwifery contribution within a wider framework has been made explicit globally (Renfrew *et al* 2014). The Institute of Medicine defines quality in health care as care which is 'safe, effective, patient-centred, timely, efficient, and equitable' (IoM 2001). While the precise mechanisms are not fully understood, qualitative research findings suggest that advocacy, trust, choice, control and listening to women are important processes linking relational continuity with improved outcomes and experience. Such models:

- Facilitate the healthcare professional being oriented towards the woman and her community, rather than towards the needs of the institution. Midwives are uniquely placed to follow, and care for women across organisational boundaries depending on their clinical risk (McCourt *et al* 2006)
- Enable midwives to utilise their knowledge of the maternity and community services, and their position as gatekeepers to those services, to pre-emptively provide care where and when it is needed (Finlay and Sandall 2009)
- Are more flexible and match input of midwives' time to women's needs especially in labour and birth (Humphrey 2002)
- Can confer benefits either as a direct effect of developing a trusting relationship with a midwife, or through additional advocacy and support from psychiatric services, domestic violence advocacy and other support (including translation services, early health visitor input, children's centres, housing and parenting support). This may have an impact on women's outcomes, safety, and ability to parent (Rayment-Jones *et al* 2015)
- Are valued by women with complex social issues who experience increased agency and control (Bulman and McCourt 2002)
- Receive higher ratings of maternal satisfaction with information, advice, explanation, venue of delivery, preparation for labour and birth, and choice for pain relief (Kelly *et al* 2013).

## What do women want?



## Women's experiences of relational care

The women featured here received relational continuity of care from their midwives, and provided the following accounts of their experiences.

### Relational continuity for younger women

**Allison – a service user:**

*My community midwife really did go all out to ensure I received her care solely - antenatally, at Ellery's birth and postnatally. Receiving such care was so instrumental to my wonderful experience and a world apart from my previous two births where the care model was very different. My midwife wasn't on call when I went into labour but she managed to get her colleague to cover her clinic so that she could be with me - I am forever grateful for her determination to attend my birth. It's almost impossible to capture in words the importance and impact that continuous care throughout pregnancy, birth and the postnatal period has - it really is priceless and has a life and soul changing impact. After my experience I can honestly say I'm in love with my midwife – writing that seems almost ridiculous, but the care and tenderness she gave me was anything but.*

**Kaydine – a service user:**

*Having your first child and knowing you carry life is the most incredible moment in anyone's life and having a midwife who can guide you all the way is the most wonderful thing you could have, especially having someone to call when you are worried. Your own midwife is not only someone that checks that your baby is okay and does all your checks, she is someone you can trust like a sister or a second mother.*

*My own midwife was so understanding and treated me no differently because of my age. I was also encouraged to meet a network of young mums and to this day we are as close as ever.*

### Experiencing two different models of care

**Ella – a service user:**

*During my first pregnancy, I never saw the same midwife twice at a big London teaching hospital and it was awful. I had chronic symphysis pubis dysfunction, got inconsistent advice and ended up on crutches. I was never offered a physio appointment and had to explain afresh every time I saw someone, which took large chunks of the appointment. During my birth, I was treated appallingly by the first midwife who 'looked after me'. She told me I wasn't in labour - turns out I was 8cm dilated so you can imagine how much this terrified me. I figured if it wasn't labour I must be dying. Because of this, I ended up having an epidural (I was coping really well up to this point). Due to a shift change this got topped up with a huge dose just before I was due to start pushing. I couldn't feel any contractions at all and took over an hour to push my son out (in the lithotomy position) which made my symphysis pubis dysfunction vastly worse and I could barely walk for months afterwards. The inconstant care lasted for the three further days I was in hospital. I was moved from ward to ward and at one point had to spend five hours in a corridor because they didn't know where to put me. I had a strong sense of failure and was in pain, which made it hard to leave the house and contributed significantly to my postnatal depression.*

*Second pregnancy: small local midwife-led unit with a community midwife team and a dedicated home birth team. I had every appointment at home with the same midwife, who really took the time to get to know me and to understand the trauma from my first birth. She made sure I saw a physio as often as possible. I had passed out during a vaginal exam (VE) in my first labour so we agreed no VEs, and she promised to really look after me. She was totally true to her word and my second birth was incredible: a wonderful, beautiful, transcendent experience. It had moments of difficulty (it was only a two-hour labour so very full on) but throughout it all she knew exactly what to say to me to keep me calm and in the right frame*

*of mind to do what I needed. I am so passionate about this experience that I am now chair of the user group for the midwife-led unit and have become an antenatal educator. I also help to run a Positive Birth Movement group.*

*Two-and-a-half years after my second birth, I became pregnant again. I asked for, and got, the same community midwife I had for my second birth. Sadly it turned out that it was a molar pregnancy. My midwife counselled me through it, took all my bloods (I had to have them taken every two weeks for two months) and chased consultants and results for me. Having a face I knew and trusted made the saddest event of my life more bearable. She has promised to care for me in my next pregnancy, and to arrange an eight-week scan so that I can know from the start that all is going as it should. Every woman should have care like this, and it would cost the NHS no more.*

### **Working with a team providing continuity to women with high-risk pregnancies: an obstetrician's view**

**Lucy – a consultant obstetrician:**

*I feel very strongly about the positive role the continuity teams bring. It's essential that we offer proper midwifery support to women with high-risk pregnancies, and not fall into an obstetric model of care where women may receive the medical care they need, but miss out on midwifery care. The confidence and familiarity provided by specialist teams is really important. It's very much a shared model of care; both midwives and obstetricians provide different aspects of care, but neither 'owns' the pregnant woman.*

*A team of six (WTE) midwives works well. Feedback from women shows that they don't always receive continuity from the same midwife, but they do have continuity from the team and also get an opportunity to meet all the team midwives during pregnancy. Women also really value having a team midwife care for them in labour. This makes a real difference, because a midwife who has developed expertise and had additional training on a high-risk team is able to manage the conditions which affect women during labour, whereas a midwife without that additional training may feel a bit uncertain about the medical management of high-risk cases.*

*When women come to us as referrals from smaller centres or district general hospitals, they may have experienced midwives and doctors who are a bit nervous of their conditions and unsure how to support normality. Continuity team midwives can reassure women that they can still have a positive experience of pregnancy and aim towards a normal birth; if this is not feasible, women can experience normality within their pregnancy care, even if they have multiple comorbidities. When working with women at additional risk, these midwives do a skilled job of providing the usual care for a pregnant woman, whilst remembering their medical complexities and having a sense of awareness and willingness to discuss these with me, or to make a referral. That balance is what keeps women safe. The midwives are integrating midwifery care with advanced practice and providing midwifery care through a very holistic model.*

*Another element of safe care is that as a consultant, I operate an open door policy. I encourage the midwives to pop in at any time, or just to pick up a phone or write an email and ask if they are unsure about anything. When new midwives join the team, I go and talk to them so they know they can come to me with questions. Sometimes, midwives just have a feeling about someone, or a sense of concern that they can't quite put their finger on, and I really try to listen to these midwives. I don't mind how non-specific the concern is, I just trust their judgement that something isn't quite right. I do encourage midwives to trust that 'sixth sense', and I think that acts as an additional safety radar, as midwives often hear things from women that they don't always tell their consultants.*



*I think it's also important for midwives to know that they don't have to know everything, because we share the responsibility together. Similarly, I share concerns I have about women with other consultant obstetric colleagues, and so throughout the extended team we role-model seeking a second opinion, and midwives can see that it's okay to ask questions.*

*Not all consultants feel the same way about these teams, but I do encourage colleagues to see the positive aspects, and if they feel reluctant, I ask what evidence they have to support their concerns. I honestly don't see any downsides, and I've worked in this model for ten years. We need trust, respect and willingness to provide high-quality care for medical conditions whilst normalising pregnancy too; the continuity model achieves all of that.*

### **Advocacy and informed consent**

There is good evidence that relational continuity models provide a basis for trust, advocacy and sharing of information between women, midwives and obstetricians, as well as the wider team as needed. This provides an ideal context for supporting informed consent.

The recent *Montgomery v Lanarkshire Health Board* ruling by the UK Supreme Court reaffirmed women's right to make autonomous decisions about pregnancy and birth, and to be given sufficient information about 'any material risk' that could influence these decisions. Elizabeth Prochaska, from Birthrights (Prochaska 2015b), discussed the implications of this ruling for the process of informed consent, advising that health professionals (doctors and midwives) must have a dialogue with women about birth decisions to ensure women understand 'material risks', benefits and alternative treatment options. In this context, a material risk is understood as a risk which is considered significant to the person involved. To meet the obligations of the *Montgomery* ruling, the information should be shared in a way that the woman understands, and it is likely that an effective relationship between a woman and her midwife will promote understanding, sharing of information with the woman and within the wider team, and conversations that give women opportunities to explore and ask questions.

### **What have we learned from the wider literature on continuity in health care?**

We know from the wider literature that there is often a lack of alignment between the priorities and resources of disadvantaged patients and the organisation of health services (Dixon-Woods *et al* 2006). Continuity of care in complex organisations is associated with improved access to care and patient safety, particularly for women with socially or medically complex histories who may otherwise fall through gaps in services (NICE 2010). A fragmented and distributed system allows disadvantaged populations to fall through gaps in services (World Health Organisation 2008). Continuity of care is associated with: improved self-care and knowledge; reduced length of hospital stay; decreased medical costs; better quality of life; fewer hospitalisations and emergency department visits; increased knowledge of whom to contact about care / service (short- and long-term); improved patient and caregiver satisfaction, with greater interpersonal trust; and perceived higher quality of care in relation to care planning (Heaton 2012, Parker 2011). We also know that only relational models of care have been shown to impact on clinical outcomes (Freeman *et al* 2007); that is, similar benefits are not found from management continuity or information continuity alone.

Maternity care is in a unique position in the UK, because midwives are able to provide care to women in their home, community and acute settings. This enables maximum choice and safety with no financial or organisational barriers.

### Continuity of care hierarchy



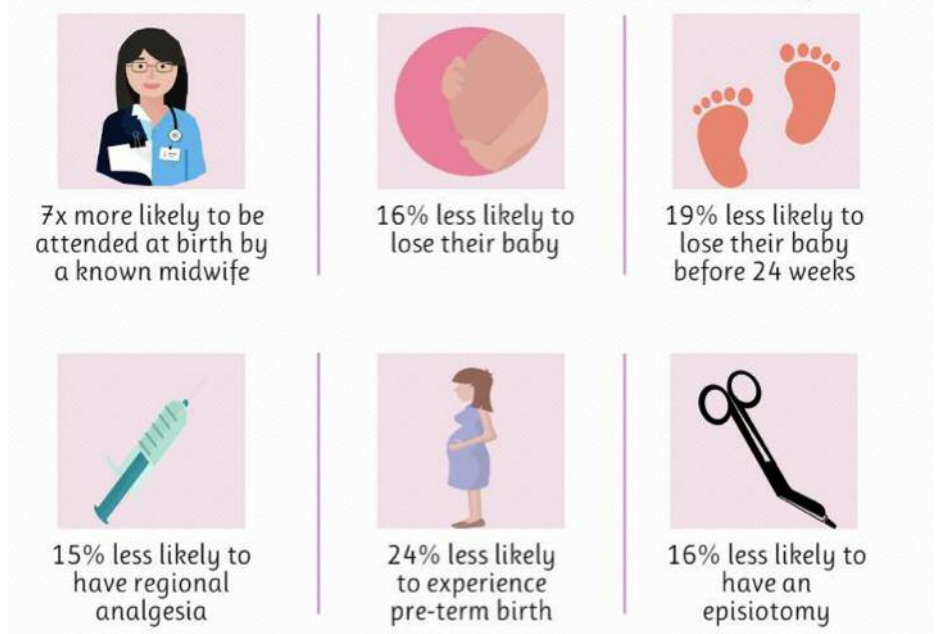
This report argues the case for a shift towards the implementation of relational continuity models of midwifery care, because these show promise in effectively tackling disparities within maternity care and improving outcomes for women and babies, and women's experiences of maternity care.

# Continuity of care: improving outcomes and experience through relationship-based care

## Relational continuity for women including those living socially complex lives

Recent high-quality evidence shows that women who receive care from a midwife they know are less likely to experience preterm birth, lose their baby before 24 weeks' gestation or lose their baby at any gestation. Women are also more likely to have a vaginal birth, to have fewer interventions during birth, and to have a more positive experience of labour and birth. Importantly, all of these findings also apply to low- and mixed-risk populations of women (Sandall *et al* 2015).

### Women who received models of midwife-led continuity of care



### Improving outcomes and experiences for women and babies

There is currently insufficient high-quality evidence to recommend implementing a specific model to reduce infant mortality in disadvantaged populations (Hollowell 2011). Other studies have found that women who carry social complexity and find services hard to access particularly value midwifery continuity models of care (McCourt *et al* 2000, Bulman and McCourt 2002, Finlay and Sandall 2009). In their single site observational study, Rayment-Jones *et al* (2015) found that women with complex social factors who received a caseload midwifery model benefitted in a number of ways:

- They had fewer caesareans, fewer antenatal admissions and a shorter length of postnatal stay in hospital
- They were more likely to have a spontaneous vaginal delivery, to give birth in a midwife-led setting, to be referred to specialist support services, and be booked for maternity care by ten weeks
- Babies of these women had reduced neonatal admissions.

In addition, women who receive continuity of midwifery care report higher ratings of maternal satisfaction with information, advice, explanation, venue of delivery, preparation for labour and birth, choice for pain relief, behaviour of the carer and control, are more positive about their overall birth experience, and have increased agency and feel less anxious (Mclachlan 2015).



### Women's experiences of relational continuity

Tallah – a service user:

*I met my midwife when I found out I was pregnant and went to see my GP. She was at the surgery and seemed really friendly and kind. I was 17 then and I hadn't been pregnant before, so it was really scary at first and I didn't know what to expect, or what midwives did really. I liked seeing the same midwife at all of my appointments, especially as I had a lot going on at home, so I didn't need to keep telling her about all that stuff and she would understand if I couldn't come to an appointment and would ask me when I could come and where I wanted to see her. Because I turned 18 before my baby was born, it meant I wouldn't be looked after by social services anymore and so my midwife and social worker helped me find housing.*

*My midwife showed me the birth centre that had a birth pool. I didn't really know anything about having a baby and that you could have one in the water so I probably wouldn't have gone there if she didn't show me around because it sounds quite scary! We also did some appointments at the birth centre so I knew where to go and what to expect when I got there. I had my baby girl in the birth pool, with my mum, auntie and midwife there to help me. We got to go home the next day because my midwife was coming to see me. I was worried about not seeing my midwife after a couple of weeks but she got my health visitor to come with her to the last appointments at my house. I still see her at the young mums group where we all bring our babies to be weighed and have done some activities like art therapy, baby massage and given each other manicures.*

*I think it's really important to know who your midwife is so you're not as scared about having a baby and they know what support you need before your baby is born.*

## Women's Experience

Women attended at birth by a known midwife reported higher ratings of maternal satisfaction with...



Information



Advice & Explanation



Place of Birth



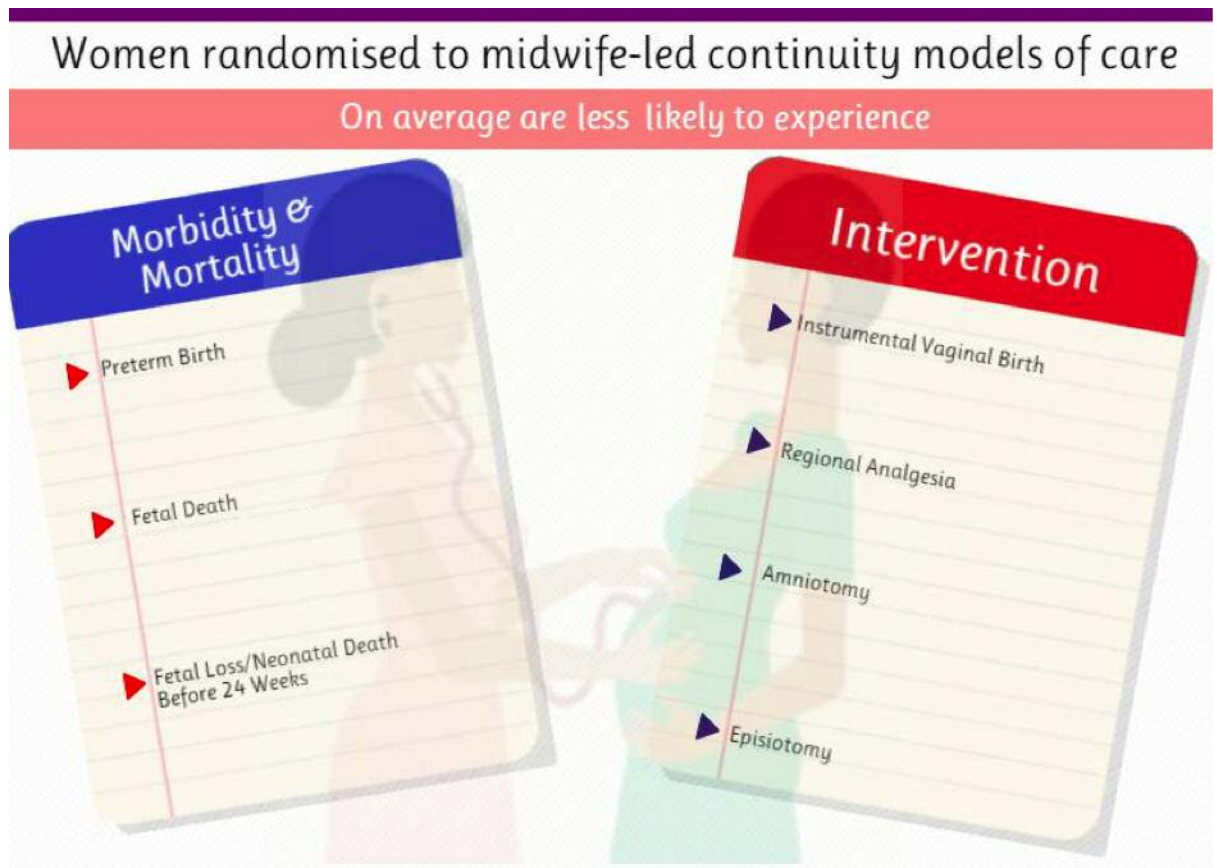
Preparation for Labour and Birth



Choice for Pain Relief



Feeling in Control

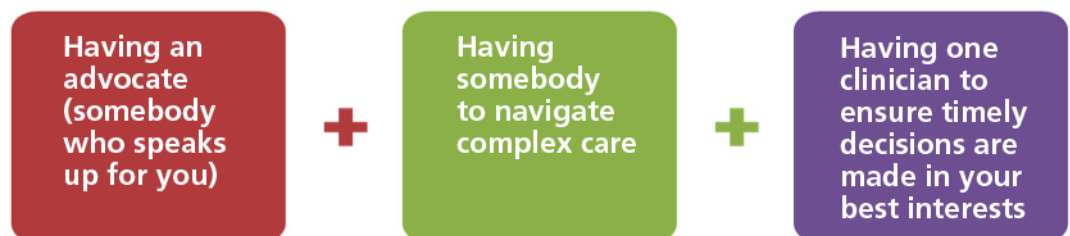


Current evidence from studies using an intention to treat analysis of midwife continuity of care models suggests a cost-neutral impact (Kenny *et al* 2015). The differences in cost stem from shorter hospital stays and the lower level of some tests and interventions. Cost savings will depend on caseload size, coverage and scale up and case-mix. However, current research draws on economic evaluation methods and further research is required.

# Continuity models of maternity care: descriptions and features

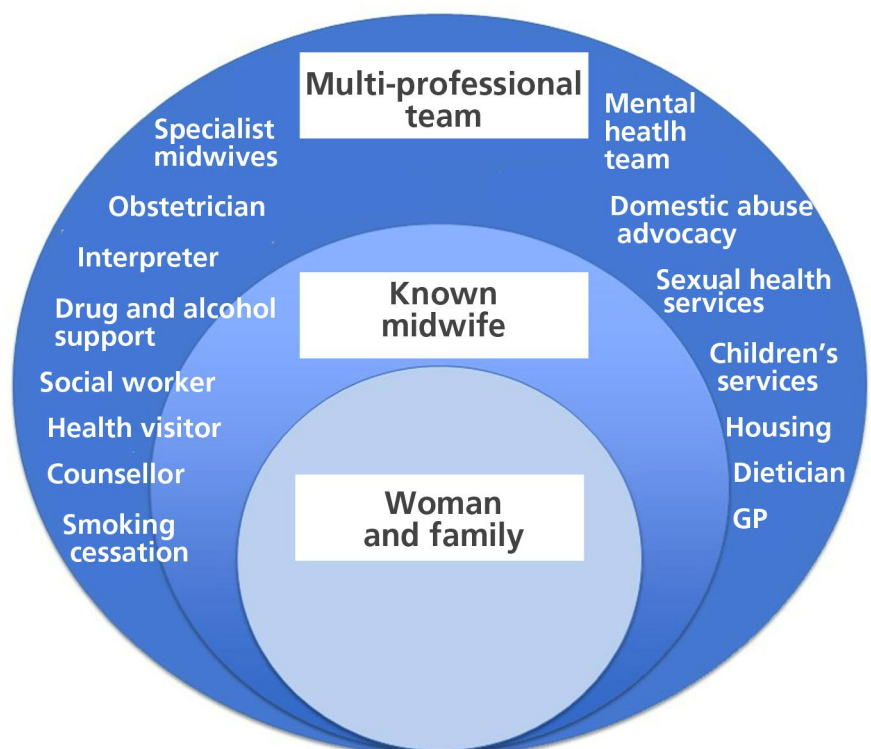
In continuity models of maternity care, women's care is provided by a single midwife known to the woman, who sees her consistently during pregnancy, provides wrap around care, and is her main or first point of contact. Of critical importance is that the primary midwife, backed up by a partner midwife, is supported by teams of specialists and can refer the woman to others (including a link obstetrician, social services, health visitors, physiotherapy, or to those who specialise in fields such as complex obstetrics or mental health). The primary midwife coordinates and navigates care for the woman, is an advocate for her, and maintains oversight so that care remains personalised, with the woman and her needs as the key focus for all.

## Relational continuity: benefits for women



Successful models of continuity of midwifery care have been aimed at women with medical, obstetric or social risk factors, where midwives act as the primary carer professional, liaising and aiding communication between the woman, her family and the multidisciplinary team. Such models build relationships of trust between care providers.

## Relational continuity: placing women and family at the centre of care to improve communication with a multidisciplinary team



A number of maternity care providers across the UK have successfully implemented

continuity of care services to enable improvement in the relationship between women, their families and care providers. Different ways to implement continuity of maternity care for women and their families include:

■ **Caseload care:** Antenatal, intrapartum, and postnatal care is provided by a named midwife. This midwife provides out-of-hours cover for intrapartum care, and when unavailable will hand over to her partner midwife who has usually met the women during their pregnancy. The named midwife collaborates with the medical team in the event of identified risk factors, as well as other multidisciplinary services

■ **Team care:** Antenatal, intrapartum and postnatal care is provided by a small team of typically six to eight midwives. Women will have a named midwife, but may meet the whole team during their pregnancy and the team share out-of-hours cover. The named midwife collaborates with the medical team in the event of identified risk factors, as well as other multidisciplinary services.

Current evidence does not suggest that there are any significant differences in outcomes between caseload and team care models (Sandall *et al* 2015). Continuity models can be community- or hospital-based, provide care to all women in a geographical area or women who require additional specialist input, where continuity of midwifery care is provided with the multidisciplinary team. Care can be provided to women who are healthy or to those who have medical or obstetric complications. Every woman needs a midwife and some women will need additional care from a range of specialists. In all these models, care can be provided by a team or caseload models.

### Examples of models of care

	<b>Geographical community-based group practice</b>	<b>Women with complex social factors</b>	<b>Women with medical co-morbidity</b>	<b>Women with specialist needs</b>	<b>Home birth</b>
<b>Level of continuity</b>	Named midwife continuity of carer throughout care pathway, plus multidisciplinary team as required	Named midwife continuity of carer throughout care pathway, plus multidisciplinary team as required	Named midwife one stop multidisciplinary antenatal clinic; 24-hour team cover for intrapartum care, usually in an obstetric unit; named midwife postnatal care in community	Named midwife continuity of carer throughout care pathway, plus multidisciplinary team as required	Named midwife continuity of carer throughout care pathway, plus consultation and referral as required
<b>Population</b>	All clinical risk population	All clinical risk population	High clinical risk	All clinical risk	Low clinical risk
<b>Setting</b>	Community-based	Community- or hospital-based	Hospital-based	Community- or hospital-based	Community-based
<b>Intrapartum care</b>	Home, midwife unit or obstetric unit	Home, midwife unit or obstetric unit	Midwife unit or obstetric unit	Home, midwife unit or obstetric unit	Home
<b>Criteria</b>	GP or postcode	NICE and local criteria	Medical co-morbidities	Local criteria, teenagers, mental health	NICE criteria

## Experiences of relational continuity by multidisciplinary professionals

### Tamsin – a social worker:

*Having worked alongside a caseload midwifery team who specialised in looking after socially vulnerable women, I recognise a number of benefits to both women and social workers. Having the opportunity to meet face-to-face with a midwife you know makes accurate information sharing much easier and saves huge amounts of time. From a social worker's perspective, assessing risk and need is much easier if they can access a small team of midwives who are aware of high-risk cases. There is less loss of information and everyone is on the same page - this minimises the risks of new and unforeseen information cropping up at multidisciplinary case conferences. Women appreciate not being asked the same information over and over again and they start to build trusting relationships with their care providers. This in turn lessens the likelihood of misinterpretation and misrepresentation. Another benefit of this is that follow up and follow through of support services is more efficient.*

*Joint visits between the woman, midwife and social worker (either in the home or hospital) are also a real asset as it enables different perspectives. When women see professionals they trust working collaboratively not only are their fears of social care somewhat alleviated, but they are also more likely to disclose sensitive matters such as worsening mental health or domestic violence. A good relationship between a midwife and social worker allows them to put forward stronger arguments for extra support for those women most in need.*

### Roberta – a health visitor:

*After working closely with midwives in a caseload care model it is clear to me that women benefit from this service; they appear to have a close bond with and a good level of trust in their midwife and they seem more comfortable talking to them. The midwives respect the women they look after and I think that this has an impact on the better outcomes the women experience, for example in relation to breastfeeding and bonding with their baby.*

*For me, it is reassuring to know that women have been looked after by the same midwife as they will be able to give a good history and handover to us, particularly with those women who have difficulties or child protection plans. Those midwives know the woman's journey. I trust the midwives in the team and always conduct a face-to-face handover at the family home. Often we have been in contact whilst the woman is pregnant to make sure plans are in place before she gives birth. Overall, it is a pleasure to work with a midwife you know, and I think women feel they are getting the best care possible.*



# Scale up and implementation

Implementation of models of continuity of care involves complex, large-scale transformation.

**'Large-scale transformations in health care are interventions aimed at coordinated, system wide change affecting multiple organisations and care providers, with the goal of significant improvements in the efficiency of health care delivery, the quality of patient care, and population level patient outcomes.'**  
(Best *et al* 2012)

This type of change requires whole system support, with close alignment between top and frontline leadership, often across a number of organisations (Turner *et al* 2016). Simple rules (Best *et al* 2012) can provide a guiding framework for successful implementation of models of continuity of care, which can be applied flexibly and provide a useful structure for policymakers and managers to help with the change process (see table 1). The London Maternity Strategic Clinical Network developed a toolkit for implementing continuity, which may be used as an implementation resource or to inform new resources (London Maternity Strategic Clinical Network 2015).

## Leadership

Experience suggests that to create and sustain working models which support relational continuity, there is a need for regional, system-wide leadership, underpinned with the political authority to align stakeholders, who should assume a leading role in supporting the move to new models of maternity care by coordinating the change process. Informal leadership via networks and by knowing key people with influence (including women, clinicians, managers and policy makers) is also important. Strong midwifery and medical leadership can be supported by system-wide authority structures such as strategic maternity clinical networks.

### **Mitra – a matron for antenatal care:**

*The key to sustainability of caseload midwifery is, firstly, that the model is supported by the senior management team and, secondly, that midwives are recruited specifically, and are continually supported. It is important to allow caseload midwives to exercise their autonomy and to ensure that they are well linked with consultant midwives, consultant obstetricians and midwifery supervisors. It is also important that they have regular training to further enhance their skills and autonomy.*

*Caseload midwives value the leadership and support they receive, the autonomy to practice as they wish within a continuity model, being in control of their diaries, having the support of the multidisciplinary team and working in partnership with women. The challenges arise from staffing a service that includes caseload and traditional models of care. For the whole service to be safe, caseload midwives need to be designed as part of the wider community service and may need to cover the unit at busy times to support colleagues and visit women in traditional teams. The important part of sustainability is that the teams book women to their full capacity so that they have better continuity with their own women whilst on call. But there will always be some flux in demand, and one of the most important parts of supporting caseload teams is to monitor how well they manage their time and achieve a good work-life balance.*

## History of change

Before implementing change it can be helpful to reflect on past efforts to change services and their outcomes, as well as the contextual factors and mechanisms that were influential and/or unsuccessful (Best *et al* 2012). Small-scale models piloting continuity of care are a useful way to demonstrate to stakeholders that the change

is possible and worthwhile (Brown and Duthe 2009; Caldwell *et al* 2008; Harrison and Kimani 2009; Lukas *et al* 2007; McGrath *et al* 2008). Once the pilot has provided proof of concept, organisational members will be more willing to scale it up to a larger system change.

In the accounts below, leaders reflect on their experiences of implementing and sustaining relational models of midwifery care.

### **Leaders reflect on their experiences of implementing relational models**

#### **Pauline – a consultant midwife:**

*Having set up caseload midwifery in two hospital trusts, I can say confidently that although there are practical challenges to overcome, these are far outweighed by the benefits to women, to midwives and to the maternity service as a whole. Some of the challenges include: balancing the availability of midwives for vulnerable women in labour with the need to attend necessary external case conferences; providing a workable on-call rota; ensuring caseload midwives understand that they cannot be providing everything that families need and that some issues are out of their remit as midwives; and ensuring caseload midwives have the necessary support during long labours. In terms of the benefits for midwives, seeing them develop and grow in their confidence and skills is very evident. For women, we know that they are more likely to have a normal birth and avoid interventions like episiotomy, perineal tears and caesarean sections, but are also more likely to be referred to perinatal mental health services.*

*My recommendation to other hospital trusts is that they understand the evidence for caseload and are clear about the model of care they want to provide. They also need to understand what factors are necessary in terms of preventing burnout for the midwives, as this is bound to be raised as an issue, for example, autonomy over their working lives, relationships with women and good social support networks. (Having said that I do believe the burnout issue is more relevant and likely in other areas such as busy labour and postnatal wards.)*

#### **Maureen – a clinical governance lead (One to One Limited):**

*Almost six years of offering this model of care has taught us to be flexible to the needs of both mothers and midwives. Change in delivering the model may be necessary to ensure work-life balance. Midwives' protected time off and annual leave must be comparable to the time and commitment put in by midwives. The results for women are widely known and are reflected in our own year-on-year outcomes for women through the risk spectrum. For midwives, the positive outcomes include increased autonomy and enhanced job satisfaction - the opportunity to be a midwife.*

*With a different way of working comes added stress, and while models can be adjusted, what is more difficult to address and causes a significant amount of stress and low morale for midwives is the clash of culture that midwives encounter as they try to interact with the multidisciplinary teams at local trusts. There is a reported lack of professional respect and a heightened inappropriate response from trusts and clinical commissioning groups when an incident occurs. Caseload midwives need to be supported by their organisation, their professional body and by each other. There also needs to be two-way communication, and multidisciplinary team meetings are essential to ensure safe, quality care for women, and a supportive environment for midwives to work as autonomous practitioners.*

#### **Victoria – a community services manager:**

*When the midwives providing the service are passionate about building a relationship with the women they care for, not only is it transformational for the women and families in their care, but it is also a very low maintenance service to manage. In my view as a manager what the midwives need to know is that you will be available to support them when needed (24/7). By knowing*

*this and by having a regular monthly meeting to review any challenging cases, discuss any management issues and any training required, highly functioning teams are relatively self-managing. Having the right midwives providing the service is the lynchpin to high-quality care. Their flexibility to work extra hard during the peaks, and rest during the lulls, while always supporting each other, is imperative.*

*Caseload midwives / teams develop strong links with all members of the multidisciplinary team, social care and third sector services, ensuring holistic care. As with all aspects of the maternity services, there are times when challenges arise. These are usually when a midwife starts working in this model and it is not the way they had envisioned it would be. In my experience, they either find their way through support and development, or apply for another position. The other challenge comes mainly between the caseload midwives and the core hospital staff, as at times the caseload midwives are not seen to be part of the team. I have addressed this through the manager-to-manager route if the midwives have unsuccessfully managed this independently.*

*To any trust considering implementing a caseload service, I would recommend the following:*

- *Decide if the service will be covered by geography or vulnerability. If the caseload consists mainly of women living with complex circumstances, the midwives should have the appropriate financial remuneration*
- *Ensure the job description and interview clearly set out the expectation on the midwives (especially the number of on-calls)*
- *Make sure the person setting up and managing the service, understands and believes in it, as this will enable its success.*

*As a manager, an effectively functioning caseload model is a service to be proud of as it provides women with the care they deserve.*

## Feedback and learning

Measurement is an important lever for improvement efforts in maternity care, and is likely to be valued by staff, commissioners and women (Dixon-Woods *et al* 2011). Developing universal measures of continuity of care in consultation with stakeholder groups will facilitate the change process and engender trust in the validity of the measures. The inclusion of continuity of care measures in maternity 'dashboards' (a scorecard for measuring clinical performance) would enable managers and clinicians to keep track of processes of care, outcomes and women's experiences and to identify areas for improvement (Jeffs *et al* 2014).

## Engaging clinicians

Approaches to change that mobilise professional knowledge and peer review across organisations can be beneficial (Aveling *et al* 2012). Organisations that have managed to overcome the challenges associated with implementation of continuity of care can be paired with others to share experiences, structures, and resources. However, the implications of the change for different groups of clinical staff will vary, and for continuity of care much of the impact is on the role of the midwife. Research on the midwifery workforce found that high levels of job control are a key protective factor, and longer working hours are significantly associated with burnout and mitigated by managerial support for work-life-balance (Yoshida *et al* 2013). Current evidence indicates that caseload midwifery models are associated with lower levels of burnout and higher professional satisfaction (Newton *et al* 2014), and that relationships with women may have a protective effect (Mollart 2013). Further research should focus on understanding the key features of the caseload model that are related to these outcomes to help build a picture of what is required to ensure long-term sustainability. However, the evidence currently available, if implemented, can help to alleviate stress on midwives.



### **Midwives' accounts of working in relational models of care**

#### **Elizabeth – a caseload team leader:**

*The five years I spent working as a caseload midwife were the most rewarding and educational times of my career so far. I was lucky enough to be part of a team which not only cared for the women and their families, but also for their colleagues. It is impossible to run a successful caseload midwifery team without that. It can be a very difficult job, both emotionally and in terms of the long hours spent working, but the job satisfaction is amazing. Being able to care for a woman throughout her pregnancy and beyond is very special. I will always be very proud of the time I spent in that role.*

#### **Sophie – a caseload midwife:**

*One of the most important benefits of working in a caseload model was being able to build a rapport with the women and their families. I was able to work truly autonomously and provide both holistic and individual care. I was also able to see women at their homes for appointments, which was often easier for both the woman and me, as I could be more flexible with my time.*

*There are some challenges; being on call for women can have an impact on your work-life balance as it can be difficult to make plans or travel far when you are on call. There is often a lot of paperwork involved, such as writing reports for child protection meetings and making / chasing referrals to other healthcare professionals, but this can be overcome by managing your diary so there is time allocated for paperwork. Despite these challenges, the benefits of knowing the women you look after far outweigh the negatives and I would definitely recommend all midwives to practice this model of care at some point in their career, to not only gain experience of the complex social issues many women face today, but also to become more confident in all areas of practice by working autonomously.*

### **Involving service users**

There is grassroots support for continuity of care from maternity users (AIMS, MAMA Academy, SANDS, NCT, Positive Birth Movement) which can be harnessed to heighten awareness of women's perspective and priorities, especially when this engagement is sustained (Mitton *et al* 2009). Continuity of care metrics also provide a mechanism to ensure equity and inclusivity through the representation of traditionally underrepresented groups and by the deliberate inclusion of patients' and families' voices that are typically or historically silent in the decision-making processes (Chessie 2009; Thompson 2003/2004).

**Table 1: Barriers and solutions include:**

<b>Barriers identified</b>	<b>Solutions / facilitators proposed by experts with experience who have addressed these or similar issues</b>
<b>Leadership</b>	
<b>Lack of national and local support for relationship continuity</b>	Prioritise continuity models in national and local commissioning
	Design in continuity to booking systems and care pathway; document named midwife or consultant, record continuity in appointments / contacts for each visit
	Make the case for continuity; engage with women and staff Share stories; visit other sites, use videos
<b>History of change</b>	
<b>Single test site: not seen as 'embedded'</b>	Avoid single team or single site; plan wider scale change within network, in response to local case mix requirement (eg target women with complex medical or social care requirements first and build). Aim for 25% coverage initially
<b>Engaging clinicians</b>	
<b>Inter-professional tensions; model not supported by all</b>	Help medical and midwifery teams get to know each other and work together
	Share education meetings: teach and learn together
<b>Some midwives don't want to work in continuity models</b>	Tailor the message: examples below:
	Encourage working in continuity model as part of preceptorship / inductions
	Promote workforce flexibility; continuity may be something midwives do for part of their career, which enhances skills and strengthens CV
	Offer time limited rotations into continuity models
	Link continuity skills to appraisal and increments (to show equivalence with other skills)
<b>Belief that midwives get burnout in continuity models</b>	Ensure good leadership, example setting and supportive culture where work-life balance is promoted
	Enable control and autonomy over own work and shifts
	Share examples when good relationships with women and colleagues improves working lives

**In addition there are resource and incentive barriers:**

<b>Barriers identified</b>	<b>Solutions / facilitators proposed by experts with experience who have addressed these or similar issues</b>
Financial constraints and acute care incentivised	Consider enhanced tariff for achieving continuity, especially for women with complex medical and social conditions
	Salary structure: consider workarounds such as increased annual leave in return for providing continuity or extra on-calls
	Enable self-rostering and autonomy over diary management
Difficulties sharing information within network	Enhance IT processes and support: commission IT that supports continuity and works across primary/acute sectoral care
Limited space or facilities	Provide space in local or community settings

# Evidence gaps and recommendations for future research

This report shows that there is good evidence for improved clinical outcomes from continuity models of maternity care, but there are also gaps in the evidence.

The Cochrane review (2015) provides high-quality evidence about outcomes using international data. This is valuable evidence about the benefits of continuity for women, but its findings do not pinpoint what models are most effective in which settings, or show benefits for particular or specific populations; for example, are the benefits of continuity equivalent for women with complex medical or obstetric conditions and for those with relatively straightforward pregnancies? Are improved outcomes found amongst women with different specific needs, such as younger women, or women with complex social problems? Are the benefits of continuity consistent across different countries and healthcare economies?

There are a number of potential questions which require further research into continuity models of maternity care. The following list highlights gaps in the existing evidence, but is not exhaustive:

- Cochrane reviews, or other evidence syntheses, might focus on consistency of intervention and outcomes in different countries or health economies, amongst populations with particular needs, and focus on midwife-led care compared to continuity with other healthcare professionals
- There is insufficient up-to-date information about the economic costs and benefits of continuity of care, and more research on this topic, both at national and international levels, is much needed to inform commissioning and service provision. A cost-effectiveness study which encompasses pregnancy and birth, with potential to undertake longer term follow up of outcomes for women and babies, would be highly valuable
- There is little research on the scale up and implementation of continuity, or the theoretical basis for understanding how relational continuity models might work. Well-designed implementation research would provide much needed evidence of the impact of continuity care, using a range of models and settings
- Research that identifies features of the continuity model that are related to improved outcomes would help build a picture of what is required to ensure the long-term sustainability of the model. Observational studies or case studies could provide data of this nature, and a realist review might help isolate which elements of relational continuity work best, for whom, and under what circumstances
- There is some exploratory research on experiences of continuity from the perspectives of midwives, managers and women, but further research into contemporary experiences of working in continuity models, and a qualitative evidence synthesis of this work, would help inform additional research and identify gaps in the evidence base
- Further research is needed to understand staff experience of working in continuity models and to explore relationships between rewards, flexibility, burnout and work-related stress within these models.

# Conclusion

This summary has been written following the Sheila Kitzinger study group at Green Templeton College, Oxford, in which professionals, users of the services, leaders and academics from a number of disciplines considered the needs of women and their babies and families being cared for during maternity, and developments that are critical to safe, high-quality care sensitive to individual and community needs. Our vision is ensuring that all childbearing women have access to continuity of care by a known midwife. Relational continuity was accepted through consensus as the most critical development. It was agreed that recommendations should be made from the evidence available, and with a view to implementation and scale up.

Despite good evidence of benefit, there has been little sustainable development of relational continuity models of care in the NHS. Past attempts at providing continuity of care, since publication of *Changing Childbirth* (Department of Health 1993) highlighted its importance, have not become mainstream. However, the evidence is now too strong to ignore. Continuity models of maternity care improve outcomes for women and for babies, and women who receive care from a known midwife have better experiences of maternity care and fewer interventions.

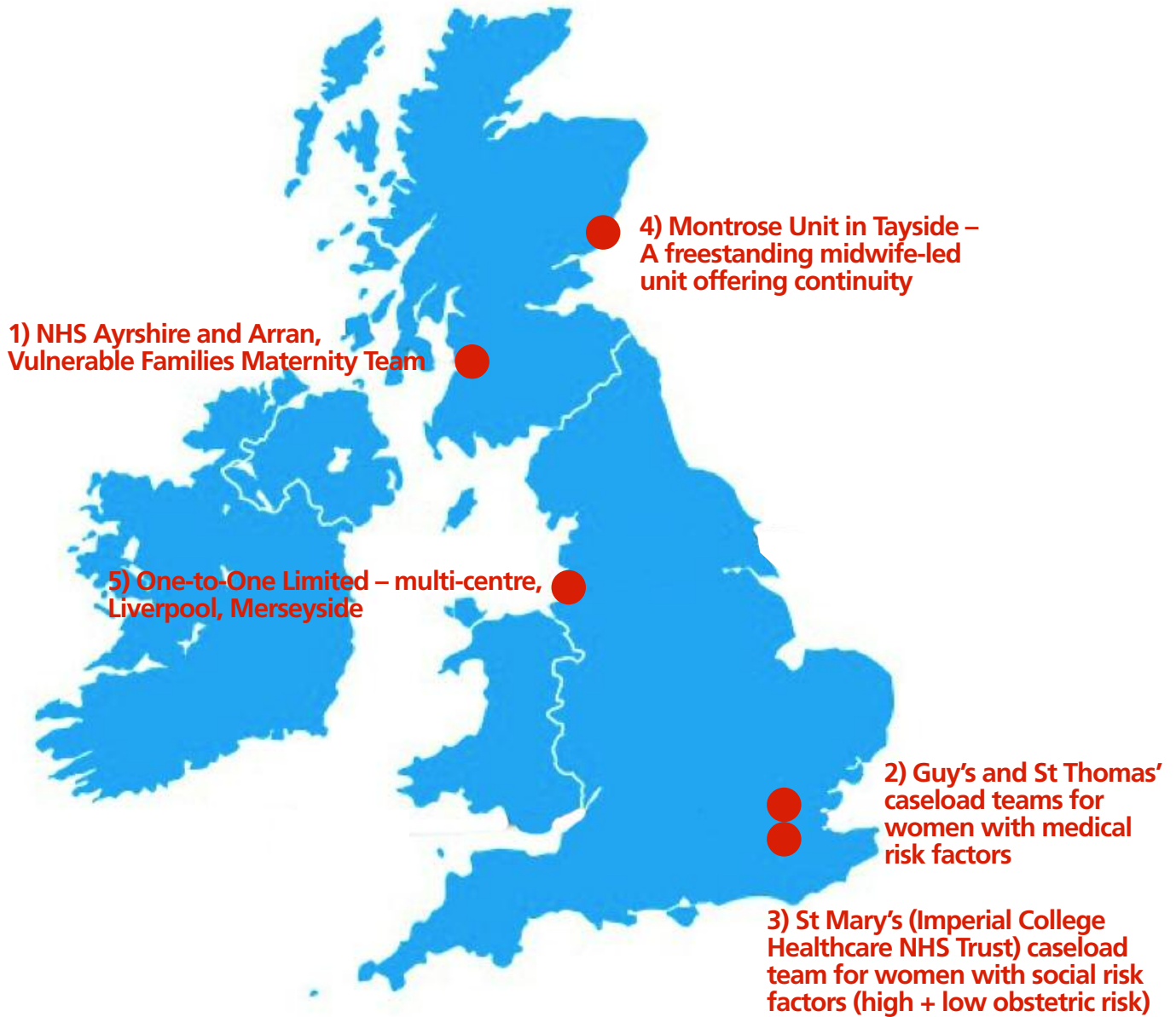
This report suggests that relational continuity be scaled up because there is compelling evidence that ongoing supportive relationships between women and their maternity care provider improves outcomes and experiences of care. Outcomes improve for women at both low and high risk of medical and obstetric complications, and benefits of continuity are also experienced by women with complex social problems, longstanding histories of mental illness, socio-economic deprivation and those from black and minority ethnic backgrounds. These are the very groups who are at higher risk of maternal and infant death and morbidity as a result of pregnancy and birth, and who more often experience failures in care.

The evidence presented here includes a Cochrane review of continuity models in maternity care, as well as findings from the Kirkup Report on the inquiry into care at Morecambe Bay and epidemiological data about maternal and infant mortality from MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK). Of equal importance is the evidence that comes from women, and from groups representing women and families who have experienced death and loss. Our symposium included a number of such groups, and heard evidence of poor and dehumanised care from Birthrights, a group which campaigns for maternity services to provide respectful care and dignity during birth.

We recognise that relational continuity models of care are reputed to be costly. Yet, the best available evidence suggests that continuity models can be achieved without extra financial resource, although additional investment may be required for improvements to IT systems for information sharing purposes, and to data gathering systems required for audit and to detail changes in outcomes.

As well as presenting evidence on improved outcomes, this report proposes that appropriately supported continuity models will provide services that are sensitive to the needs of women, and can also improve job satisfaction and a sense of autonomy for midwives that practice in these models. Key to this is good leadership, allowing grassroots development of local models which address local needs, with supportive supervision, and realistic planning underpinned by positive multidisciplinary collaboration. NHS staff already want to provide the best care to women and families, and leaders in maternity care feel passionate about providing safe, high-quality care through relational continuity. Continuity of care keeps women and babies safe and helps health and social care professionals to provide collaborative complex care and expertise in the best interests of the woman.

# Examples of continuity of care services



## 1) NHS Ayrshire and Arran, Vulnerable Families Maternity Team

### Description of service:

A midwifery service which responds to policy drivers by providing individualised care to families with socially complex needs through partnership continuity in the antenatal and postnatal period. Referral to the team follows the 12-week scan; women receive care at home or in the clinic. The named midwife ensures referral and continuous liaison to support services with a strong emphasis on multidisciplinary working and child protection.

**Challenges:** Providing intrapartum care difficult due to the size of the team and priority placed on case conference attendance. Low homebirth rate due to social complexity; currently trying to facilitate choice in place of birth through forward planning and advocacy. Now working on earlier intervention by named midwife undertaking the initial booking appointment.

### Process and outcome data:

Improvement in outcomes for the family for example; increased support and involvement in health style choices from the whole family; smoke free homes, interaction with children, uptake in parenting programmes and increased breastfeeding rates.

Continuous audit over the past four years found an increase in referrals to the team, and despite increasing number of referrals to social care a 24% decrease in unborn children on the child protection register at birth, and a 36% decrease in child protection orders at birth. This is thought to be due to early referral to social care and input from support services for the family.

Issues	Facilitators
Funding	Introduced within existing resources freeing up 37.5 hours per week of midwives' time.
Implementing change	Response to policy drivers, audit of current services and local population needs. A team was reorganised as a pilot and audited regularly.
Wellbeing of midwives and the team	Weekly meetings and child protection advisor. One FTE split over two midwives to reduce risk of burnout: partnership midwifery. Regular debriefing sessions.
Workload and rotas	Very flexible dependant on midwives needs. Some midwives work full-time in VFT, some work half vulnerable families' caseload, other half 'low risk' women. Postnatal period is extended to 28 days. Intrapartum care not provided by team.
Retention and sustainability	The service has been running successfully since 2011 and has been replicated in another area.
Maintaining skills and staff development	Newly qualified midwives are encouraged to work on the team as part of their preceptorship to develop a range of skills. The midwives in the team are all supported to attend local multi-agency training about child protection. All midwives recruited to the team with substantive contracts are expected to undertake the postgraduate diploma from the University of the West of Scotland in Child protection.

## 2) Guy's and St Thomas' caseload teams for women with medical risk factors

### Description of service:

Two teams of seven midwives provide continuity of care for approximately 700 women a year. Referrals from GP or self-referral. The booking midwife coordinates all antenatal and postnatal care and attends all multidisciplinary consultations to ensure access to specialist services and shared care plans. The team aims to provide as much intrapartum continuity as possible through an on-call system. Care is provided from children's centres in the local community. Each team consists of one band 7 midwife and six band 6 midwives.

### Process and outcome data:

Antenatal care provided by the same midwife 65% of the time, intrapartum care by the same midwife drops to 30%. Annual data collection shows all women had an agreed multidisciplinary care plan in their notes and experienced timely referral to the high-risk team. A research project to evaluate health outcomes is currently being explored.

### Feedback: "Fantastic midwife team.

Have had an appointment to meet all the midwives but also having an assigned midwife to do home visits is so appreciated. It has given me a lot of confidence as this is my first pregnancy and continuous contact during the past weeks is excellent."

"Like flexibility of home visits and comfortable with consistency of midwife, so I don't have to repeat my medical history/situation which makes visits more efficient."

Issues	Facilitators
Funding	No new funding was required for staffing. Posts were found through the creative reorganisation of existing posts in the unit. IT investment approved by trust board.
Implementing change	Engaging, value-based recruitment process including internal meetings to share known benefits of continuity. Engagement of commissioners and maternity service liaison committee.
Wellbeing of midwives and the team	Weekly team meetings in allocated team office, frequent appraisals and an annual away day.
Workload and rotas	Organised around specialist clinics and ward round to ensure midwife can attend. One mobile phone per team and on-call midwife from team factored into the rota.
Offering continuity throughout antenatal intrapartum and postnatal period	Named midwife for booking and majority of appointments, but the focus of continuity is on the team rather than the individual midwife.
Maintaining skills, staff development and retention	Weekly multidisciplinary meetings with specialist consultants. Routine allocation for newly qualified midwives on preceptorship. Encouragement and funding for examination of the new born, supervision of midwives, and trust leadership courses.



### 3) St Mary's (Imperial College Healthcare NHS Trust) caseload team for women with social risk factors (high + low obstetric risk)

#### Description of service:

A team of six midwives provide continuity of care to socially vulnerable women and women requesting a homebirth. Women are referred by a GP, safeguarding lead or the antenatal clinic. The referral criteria were developed from NICE guidelines and local demographics. Care is provided at the woman's home or local children's centres. The named midwife attends all child protection meetings and coordinates care between the multidisciplinary team, working closely with social workers and health visitors. Each midwife has a maximum caseload of 35 women and provides intrapartum care.

**Outcome data:** An empirical study found that socially vulnerable women cared for by the team experienced significantly more spontaneous vaginal delivery, water use for pain relief, birth centre birth, early access, continuity of carer and referral to support services than socially vulnerable women accessing standard maternity care at the Trust. They also experienced fewer caesarean sections, epidurals, antenatal and neonatal admissions, and had shorter postnatal stays (Rayment-Jones *et al*, 2015).

Issues	Facilitators
Funding	No new funding as posts became available through the reorganisation of community services to meet the needs of the local population. The existing caseload midwives for women requesting homebirth were developed.
Implementing change	Focus groups were held with service users, midwives, safeguarding leads, consultant midwives and obstetricians, and key stakeholders.
Wellbeing of midwives and the team	Weekly team meetings, allocated office space at the Trust and convenient car parking, regular safeguarding supervision with lead safeguarding midwife.
Workload and rotas	The team leader coordinates off duty with a focus on flexibility. Each midwife caseloads a maximum of 35 women a year and provides intrapartum care.
Offering continuity throughout antenatal intrapartum and postnatal period	Each midwife attends all antenatal and postnatal appointments and has a mobile phone that they divert to their partner midwife when they are not working. They will be on call overnight three to four times a week to increase continuity of intrapartum care and have two full days off.
Maintaining skills, staff development and retention	Encouraged to undertake examination of the new born, newborn life support and ALSO (Advanced Life Support in Obstetrics) courses as well as academic development.

#### 4) Montrose Unit in Tayside – A freestanding midwife-led unit offering continuity

##### Description of service:

A freestanding midwife-led unit in North Angus. The team consists of 11 midwives, a maternity care assistant and a ward assistant. The midwives provide a 24-hr-service which covers routine antenatal care. For women with an identified risk, the care is in partnership with the consultant-led antenatal clinic in Ninewells Hospital, Dundee. Midwives provide triage facilities as well as ultrasound scanning. The intrapartum service is primarily for women with a low risk pregnancy. However, choice is facilitated if the recommended criteria are not met. At night, one midwife is on duty with an on-call midwife to support her when necessary.

**Outcome data:** The outcome data from Montrose continues to remain positive. For local women, over 50% will give birth locally within Montrose. The intrapartum transfer rate is variable but sits around 14% and the waterbirth rate is consistently over 70%.

Feedback from women is obtained through formal feedback sessions (The Birth-Tay forum), the Montrose Maternity Facebook page, and the usual NHS Tayside feedback process (how are we doing forms on-site). There is a consistently high level of positive feedback from the women who use this service. The feedback is used to update and improve the service and is very much encouraged.

Issues	Facilitators
Funding	This is an NHS Scotland service funded as part of the Tayside Maternity Service. There is discussion around merging two local units to ensure issues such as lone working and on calls can be addressed in a cost-neutral way.
Implementing change	The unit facilitates team meetings and meetings with other agencies (Health Visiting, Homestart). Financial pressures make change inevitable, but trying to encourage staff to be part of the innovative change needed, to discuss what they feel would work and to listen to the concerns raised helps the unit to move through the changes together.
Wellbeing of midwives and the team	The midwives work very closely as part of a team and describe tremendous job satisfaction. However, the shift patterns, on-call commitment and lone working can pose challenges for the staff.
Workload and rotas	There is continued effort to create rotas which meet the needs of the women as well as those of the midwives and staffing workload. The Angus service is currently piloting a home birth service that is attached to the unit.
Retention and sustainability	The level of midwife job satisfaction has ensured that retention of staff has not been an issue however recruiting new staff is a challenge.

## 5) One-to-One Limited- multi-centre, Liverpool, Merseyside

### Description of service:

A multi-centred, social, caseload model of midwifery where one midwife holds a caseload of approximately 32 women with support from a 'partner' midwife. Women living in a catchment area can self-refer to the service using the One-to-One website ([www.onetoonemidwives.org](http://www.onetoonemidwives.org)). The service is free to women and open to women regardless of their medical risk status. Midwives undertake most appointments in women's homes or satellite Pregnancy Advice Centres.

**Outcome data:** The service has high levels of antenatal continuity (84%), normal birth (93%) and homebirth (34%). Full outcome data is collected annually, evaluated and published.

Issues	Facilitators
Funding	Wirral Clinical Commissioning Group (CCG) funded the implementation of the service following successful outcomes in a pilot study in 2010. To implement the subsequent services, the local CCGs were approached with a business plan.
Implementing change	Following approval by the CCG and local trust, focus groups are held with key stakeholders, service users, midwives, safeguarding leads, consultant midwives and obstetricians
Wellbeing of midwives and the team	Preceptorship programme and mentors offered on appointment of post. The midwives work from home but have a base in the Pregnancy Advice Centres to see women and colleagues. Frequent team meetings and monthly 'fresh eyes' meetings where midwives discuss their caseload with the locality coordinator.
Workload and rotas	Midwives liaise with women to organise their diaries and workload in a highly flexible way. Initially midwives cared for 40 women a year, but this has been reduced to 32 in order to minimise risk of burnout. Each midwife will be on call for women in their caseload most of the time but they are encouraged to protect at least one day a week by diverting their phone calls to their partner midwife.
Offering continuity throughout antenatal intrapartum and postnatal period	Each midwife attends all antenatal and postnatal appointments and will be on call for intrapartum care. The midwives are unable to practice within the local trusts at present, but act in a supportive role when women are giving birth in hospital.

# References

- Aveling, E.L., Martin, G., García, S.J., Martin, L., Herbert, G., Armstrong, N., Dixon-Woods, M. & Woolhouse, I. (2012) 'Reciprocal peer review for quality improvement: an ethnographic case study of the Improving Lung Cancer Outcomes Project'. *BMJ quality & safety* 21(12): 1034-1041.
- Best, A., Greenhalgh, T., Lewis, S., Saul, J.E., Carroll, S. & Bitz, J. (2012) 'Large-system transformation in health care: a realist review'. *Milbank Quarterly* 90(3): 421-456.
- Birthrights (2013) Birthrights Dignity Survey  
<http://www.birthrights.org.uk/wordpress/wp-content/uploads/2013/10/Birthrights-Dignity-Survey.pdf> Accessed 31.3.16.
- Birthrights /Prochaska *et al* (2015a) Letter to maternity review  
<http://www.birthrights.org.uk/wordpress/wp-content/uploads/2015/08/Human-Rights-Letter-to-National-Maternity-Review-.pdf> Accessed 31.3.16.
- Birthrights (2015b) UK Supreme Court upholds women's autonomy in childbirth: Montgomery v Lanarkshire Health Board <http://www.birthrights.org.uk/2015/03/uk-supreme-court-upholds-womens-autonomy-in-childbirth-montgomery-v-lanarkshire-health-board/> Accessed 31.3.16.
- Bohren, M.A., Vogel, J.P., Hunter, E.C., Lutsiv, O., Makh, S.K., Souza, J.P., Aguiar, C., Coneglian, F.S., Diniz, A.L.A., Tunçalp, Ö. & Javadi, D (2015) 'The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review'. *PLoS Med* 12(6): e1001847.
- Braithwaite, J., Marks, D., & Taylor, N. (2014) 'Harnessing implementation science to improve care quality and patient safety: a systematic review of targeted literature' *International journal for quality in health care: journal of the International Society for Quality in Health Care/ISQua* 26(3): 321-9. Doi 10.1093/intqhc/mzu047.
- Brown, T., & Duthe, R. (2009) 'Getting "Lean": Hardwiring Process Excellence into Northeast Health'. *Journal of Healthcare Information Management* 23(1): 34—38.
- Bulman, K., McCourt, C (2002) 'Somali refugee women's experiences of maternity care in west London: a case study'. *Crit. Public Health* 12:365–380.
- Caldwell, D.F., Chatman, J., O'Reilly III, C.A., Ormiston, M. & Lapiz, M. (2008) 'Implementing Strategic Change in a Health Care System: The Importance of Leadership and Change Readiness'. *Health Care Management Review* 33(2): 124—33.
- Care Quality Commission (2015) 'Survey of Women's Experiences of maternity care', December 2015.
- Chessie, K. (2009) 'Health System Regionalization in Canada's Provincial and Territorial Health Systems: Do Citizen Governance Boards Represent, Engage, and Empower?' *International Journal of Health Services* 39(4): 705-724.
- Commonwealth of Australia (2009) 'Report of the maternity services review'. Canberra: Department of Health and Ageing.
- Department of Health (1993) 'Changing Childbirth: Report of the Expert Maternity Group'. London: HMSO.
- Department of Health (2004) 'National Service Framework for Children, Young People and Maternity Services: Maternity standard 11'. London: Department of Health.

Department of Health (2007) 'Maternity Matters: Choice, access and continuity of care in a safe service'. London: Department of Health.

Department of Health (2015) 'A mandate from the Government to NHS England: April 2015 to March 2016'. London: Department of Health.

Department of Health, Social Services and Public Safety (DHSSPS) (2012) 'A Strategy for Maternity Care in Northern Ireland 2012-2018'  
<https://www.dhsspsni.gov.uk/publications/strategy-maternity-care-northern-ireland-2012-2018> accessed 1.3.16.

Devane, D., Begley, C., Clarke, M., Walsh, D., Sandall, J., Ryan, P., Revill, P., Normand, C. (2010). 'Socio-economic value of the midwife: A systematic review, meta-analysis, meta-synthesis and economic analysis of midwife-led models of care'. London: Royal College of Midwives.

Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, A., Harvey, J., Hsu, R., Katbamna, S., Olsen, R., Smith, L. & Riley, R., (2006) 'Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups'. *BMC Medical Research Methodology* 6(1): 35.

Dixon-Woods M., Bosk C.L., Aveling E.L., Goeschel C.A. & Pronovost P.J. (2011) 'Explaining Michigan: Developing an ex post theory of a quality improvement program'. *Millbank Quarterly* 89(2): 167-205.

Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., McCarthy, I., McKee, L., Minion, J., Ozieranski, P. & Willars, J. (2014) 'Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study'. *BMJ quality & safety* 23(2): 106-115.

Finlay, S. & Sandall, J. (2009) '"Someone's rooting for you": continuity, advocacy and street-level bureaucracy in UK maternal healthcare'. *Soc Sci Med* 69(8): 1228-35.

Freeman, G., Woloshynowych, M., Baker, R., Boulton, M., Guthrie, B., Car, J., Haggerty, J., & Tarrant, C. (2007) 'Continuity of care: what have we learned since 2000 and what are policy imperatives now?' National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO).

Harrison, M.I., & Kimani, J. (2009) 'Building Capacity for a Transformation Initiative: System Redesign at Denver Health'. *Health Care Management Review* 34(1 ): 42—53.

NHS London Healthcare for London (2010) What women and their families need and want from a maternity service: overview of existing data.  
<http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/What-women-want-from-a-maternity-service1.pdf> accessed 17.3.16.

Heaton, J.C.A., & Parker, G. (2012) '"Continuity of care': a critical interpretive synthesis of how the concept was elaborated by a national research programme'. *International Journal of Integrated Care*, 12(2).

Hollowell, J., Oakley, L., Kurinczuk, J.J., Brocklehurst, P. & Gray, R., (2011) 'The effectiveness of antenatal care programmes to reduce infant mortality and preterm birth in socially disadvantaged and vulnerable women in high-income countries: a systematic review'. *BMC Pregnancy Childbirth* 11(1): 1.

Humphrey, C., Ehrich, K., Kelly, B., Guest, D., Morgan, M., Redfern, S. and Sandall, J., (2002) 'Policies affecting human resource management in the NHS and their implications for continuity of care'. London: NCCSDO.

Institute of Medicine (2001) 'Crossing the Quality Chasm', Washington, National Academy Press.

- Jeffs, L., Beswick, S., Lo, J., Lai, Y., Chhun, A. & Campbell, H. (2014) 'Insights from staff nurses and managers on unit-specific nursing performance dashboards: a qualitative study'. *BMJ quality & safety*, 23(12): 1001-1006.
- Kelly, C., Alderdice, F., Lohan, M., Spence, D. (2013) 'Every pregnant woman needs a midwife' – the experiences of HIV affected women in maternity care'. *Midwifery* 29: 132–138.
- Kenny, C., Devane, D., Normand, C., Clarke, M., Howard, A., & Begley, C. (2015). 'A cost-comparison of midwife-led compared with consultant-led maternity care in Ireland (the MidU study)'. *Midwifery* 31(11): 1032-1038.
- King's Fund (2008) 'Safe Births: Everybody's Business: an Independent Inquiry into the Safety of Maternity Services in England'. London, King's Fund.
- Kirkup, B. (2015) 'The Report of the Morecambe Bay Investigation'. London, The Stationery Office.
- Leigh, B., Mullins, E. & Regan, L. (2015) 'A human rights approach to women's health'. Chapter 12 in Davies, S.C. *Annual Report of the Chief Medical Officer, 2014, The Health of the 51%: Women* London: Department of Health.
- London Maternity Strategic Clinical Network (2015) 'Increasing the number of women who receive continuity of midwife care: A best practice toolkit' NHS London Strategic Clinical Networks <http://www.londonscn.nhs.uk/wp-content/uploads/2014/11/mat-coc-toolkit-042015.pdf> Accessed 23.03.2015.
- Lukas, C.V., Holmes, S.K., Cohen, A.B., Restuccia, J., Cramer, I.E., Shwartz, M. & Charns, M.P., (2007) 'Transformational Change in Health Care Systems: An Organizational Model'. *Health Care Management Review* 32(4): 309—20.
- MBRRACE (2014): Knight, M., Kenyon, S., Brocklehurst, P., Neilson, J., Shakespeare, J., Kurinczuk, J.J. (Eds.) on behalf of MBRRACE-UK. 'Saving Lives, Improving Mothers' Care - Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–12'. Oxford: National Perinatal Epidemiology Unit, University of Oxford.
- MBRRACE (2015a): Manktelow, B.M., Smith, L.K., Evans, T.A., Hyman-Taylor, P., Kurinczuk, J.J., Field, D.J., Smith, P.W., Draper, E.S., on behalf of the MBRRACE-UK collaboration. 'Perinatal Mortality Surveillance Report UK Perinatal Deaths for births from January to December 2013'. Leicester: The Infant Mortality and Morbidity Group, Department of Health Sciences, University of Leicester.
- MBRRACE (2015b): Knight, M., Tuffnell, D., Kenyon, S., Shakespeare, J., Gray, R., Kurinczuk, J.J. (Eds.) on behalf of MBRRACE-UK. 'Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13'. Oxford: National Perinatal Epidemiology Unit, University of Oxford.
- McCourt, C. & Pearce, A., (2000) 'Does continuity of carer matter to women from minority ethnic groups?' *Midwifery* 16(2): 145-54.
- McCourt, C., Stevens, T. & Sandall, J. (2006) 'Working with women: developing continuity of care in practice' in Page, L and McCandlish, R. (Eds.) *The new midwifery: Science and sensitivity in practice* (2nd ed.). Philadelphia, Churchill Livingstone.
- McGrath, K.M., Bennett, D.M. Ben-Tovim, D.I. Boyages, S.C. Lyons, N.J. & O'Connell, T.J. (2008) 'Implementing and Sustaining Transformational Change in Health Care: Lessons Learnt about Clinical Process Redesign'. *Medical Journal of Australia* 188(suppl. 6): S32-35.

McLachlan, H.L., Forster, D.A., Davey, M.A., Farrell, T., Flood, M., Shafiei, T. & Waldenström, U. (2015) 'The effect of primary midwife-led care on women's experience of child birth - the results of the COSMOS trial', *BJOG* in press.

Mitton, C., Smith, N. Peacock, S. Evoy, B. & Abelson, J. (2009) 'Public Participation in Health Care Priority Setting: A Scoping Review'. *Health Policy* 91(3): 219-28.

Mollart, L., Skinner, V.M., Newing, C., Foureur, M. (2013) 'Factors that may influence midwives work-related stress and burnout'. *Women and Birth* 26(1): 26-32.

National Audit Office (2013) 'Maternity services in England', HC Session 794, Session 2013-14.

National Maternity Review (2016) 'Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for maternity care, NHS England'.

National Institute for Health and Care Excellence (NICE) (2010) 'Pregnancy and Complex Social Factors: A Model for Service Provision for Pregnant Women with Complex Social Factors'. London, NICE.

National Institute for Health and Care Excellence (NICE) (2012) 'Patient experience in adult NHS services: improving the experience of care for people using adult NHS services (CG138)'. London, NICE.

Newton, M.S., McLachlan, H.L., Willis, K.F., & Forster, D.A. (2014) 'Comparing satisfaction and burnout between caseload and standard care midwives: findings from two cross-sectional surveys conducted in Victoria, Australia'. *BMC Pregnancy Childbirth* 14(1): 426.

Parker, G., Corden, A. & Heaton, J., 2011. 'Experiences of and influences on continuity of care for service users and carers: synthesis of evidence from a research programme'. *Health & social care in the community* 19(6): 576-601.

Rayment-Jones, H., Murrells, T. & Sandall, J. (2015) 'An investigation of the relationship between the caseload model of midwifery for socially disadvantaged women and childbirth outcomes using routine data-a retrospective, Observational study'. *Midwifery*, 31(4): 409-417.

RCM (2016) Better Births website <https://www.rcm.org.uk/better-births-initiative> Accessed 19.2.16.

Renfrew, M.J., McFadden, A., Bastos, M.H., Campbell, J., Channon, A.A., Cheung, N.F., Silva, D.R.A.D., Downe, S., Kennedy, H.P., Malata, A. & McCormick, F. (2014) 'Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care'. *The Lancet* 384(9948): 1129-1145.

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2015) 'Midwife-led continuity models versus other models of care for childbearing women'. *Cochrane Database of Systematic Reviews* Issue 9. Art. No.: CD004667.

Sandall, J. (1998) 'Occupational burnout in midwives: new ways of working and the relationship between organisational factors and psychological health and wellbeing'. *Risk, Decision & Policy* 3(3): 213-32.

SANDS (2009) 'Saving Babies' Lives Report'. London, SANDS.

SANDS (2015) Impact report 2014/15. London, SANDS

Saultz, J.W., & Albedaiwi, W. (2004) 'Interpersonal continuity of care and patient satisfaction: a critical review'. *Annals of Family Medicine* 2(5): 445.



Saultz, J.W., & Lochner, J. (2005) 'Interpersonal continuity of care and care outcomes: a critical review'. *Annals of Family Medicine* 3(2): 159.

Scottish Government Care Experience Programme (2015) 'Having a baby in Scotland 2015: listening to mothers, An Official Statistics publication for Scotland, The Scottish Government, December 2015' <http://www.gov.scot/Resource/0049/00490953.pdf>

Scottish Government (2011) 'A Refreshed Framework for Maternity Care in Scotland: The Maternity Services Action Group' <http://www.gov.scot/Publications/2011/02/11122123/0> accessed 11.3.16.

Scottish Government Getting it right for every child (GIRFEC) <http://www.gov.scot/Topics/People/Young-People/gettingitright/what-is-girfec> accessed 11.3.16.

Thompson, A.G.H. (2003/2004) 'Moving beyond the Rhetoric of Citizen Involvement: Strategies for Enablement'. *Eurohealth* 9(4): 5—8.

Turner, S., Ramsay, A., Perry, C., Boaden, R., McKeivitt, C., Morris, S., Pursani, N., Rudd, A., Tyrrell, P., Wolfe, C. & Fulop, N. (2016) 'Lessons for major system change: centralization of stroke services in two metropolitan areas of England'. *Journal of health services research & policy*.1355819615626189.

Vaughan, D. (1999) 'The Dark Side of Organizations: Mistake, Misconduct, and Disaster'. *Annual Review of Sociology* 25: 271-305.

Welsh Government (2011) 'A Strategic Vision for Maternity Services' <http://gov.wales/topics/health/publications/health/strategies/maternity/?lang=en> accessed 11.3.16.

White Ribbon Alliance (2011) 'Respectful maternity care: The Universal Rights of Childbearing Women' Washington DC: White Ribbon Alliance; 2011 Oct. [http://whiteribbonalliance.org/wp-content/uploads/2013/10/Final\\_RMC\\_Charter.pdf](http://whiteribbonalliance.org/wp-content/uploads/2013/10/Final_RMC_Charter.pdf) Accessed 24.03.16.

Yoshida Y, & Sandall J. (2013) 'Occupational burnout and work factors in community and hospital midwives: a survey analysis'. *Midwifery* 29(8): 921-6.